TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GRAPEVINE SURGICARE PARTNERS

Respondent Name
EMPLOYERS MUTUAL CASUALTY CO

MFDR Tracking Number
M4-17-1194-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JANUARY 3, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached claim was not paid according to the 2016 Texas Ambulatory Surgical Center Fee Schedule."

Amount in Dispute: $2,732.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOB(s) and the reduction rationale(s) stated therein. Also note that the provider has submitted the charges in question four different times with differing amounts…the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 2, 2016	Ambulatory Surgical Care Services CPT Code 29889-RT	$2,732.70	$0.00
	Ambulatory Surgical Care Services CPT Code 27429-RT	$0.00	$0.00
TOTAL		$2,732.70	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

- P12-Workers compensation jurisdictional fee schedule adjustment.
- 59-Processed based on multiple or concurrent procedure rules.
- B22-This payment is adjusted based on the diagnosis.
- W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is the requestor entitled to additional reimbursement for CPT code 29889-RT rendered on March 2, 2016?

Findings

1. The requestor is seeking additional reimbursement of $2,732.70 for ambulatory surgical care services , CPT code 29889-RT, rendered to the claimant on March 2, 2016.

   The fee guideline for Ambulatory Surgical Care services is found in 28 Texas Administrative Code §134.402.

   28 Texas Administrative Code §134.402(d) states,

   > For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section.

   CPT code 29889 is defined as "Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction." CPT code 29889 is classified as a device intensive procedure.

   28 Texas Administrative Code §134.402(f)(2) states "Reimbursement for device intensive procedures shall be: (A) the sum of: (i) the ASC device portion; and (ii) the ASC service portion multiplied by 235 percent; or (B) If an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and (ii) the ASC service portion multiplied by 235 percent."

   A. To determine the MAR for code 29889 is a five-step process:

   1. **Step 1-Gather factors**:

   - According to Addendum B found on CMS website, the hospital outpatient prospective payment amount for 29889 is $10,537.90.
   - The device dependent APC offset percentage found in Table 66 for National Hospital OPPS for code 29889 for CY 2016 is 53.97%.
   - According to Addendum AA found on CMS website, CPT code 29889 has a Medicare ASC reimbursement of $7,886.65.
   - The Core Based Statistical Area (CBSA-City Wage Index) located on the White House/OMB website or CMS website for Grapevine, Texas is 0.9847.

   2. **Step 2- To determine the device portion, you multiply the hospital outpatient prospective payment amount times the device dependent APC offset percentage**:

$10,537.90 multiplied by 53.97% = $5,687.30.

3. **Step 3 - Find the geographically adjusted Medicare ASC reimbursement for code 29889. This step requires calculations**:

- The Medicare fully implemented ASC reimbursement rate of $7,886.65 is divided by 2 = $3,943.33.
- This number multiplied by the City Wage Index for Grapevine, TX $3,943.33 X 0.9847 = $3,883.00.
- The sum of these two is the geographically adjusted Medicare ASC reimbursement $3,943.33+ $3,883.00= $7,826.33.

4. **Step 4- To determine the service portion:**

- Subtract the device portion from the geographically adjusted Medicare ASC reimbursement $7,826.33 minus $10,537.90 = -$2,711.57.
- Multiply the service portion by the DWC payment adjustment factor of 235% -$2,711.57 multiplied by 235% = -$6,372.19

5. **Step 5- To determine the MAR**

- Add the service portion and the device portion together

  -$6,372.19 + $5,687.30 = -$684.89

The respondent paid $10,416.52. As a result, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		6/22/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.